A Member of the OCBC Group

GROUP PERSONAL ACCIDENT CLAIM FORM

CLAIM SUBMISSION PROCEDURES

Please read carefully before you complete the attached Claim Form.

1. The Great Eastern Life Assurance Company Limited (The Company) does **not admit liability** by the mere issue of this Form.

2. Please complete and answer all questions in full and tick in the appropriate boxes provided. Please indicate "N.A", if the question is not applicable in your case.

3. This Claim Form must be supported with the following documents :-

   (i) Claimant's Statement.

   (ii) Clinical Abstract Application Form.

   (iii) Doctor's Statement (refer to note 2 below).

   (iv) All available Laboratory and Test Results.

   (v) Copy of Birth Certificate / Identity Card / Passport of the Insured Member (certified to be a true copy by an authorised senior officer of the Policyholder).

   (vi) Copy of Police Statement if the accident was reported to the Police (certified to be a true copy by an authorised senior officer of the Policyholder).

   Notes:

   1. The Company reserves the right to call for any original documents.

   2. Insured Member must request the **Attending Doctor/Surgeon** to complete the **Doctor's Statement** of this **Claim Form** and attach it to the other claim submission documents. **The Insured Member must bear the fee charged** for the completion of this medical report. **The Company will not reimburse any part of this fee.**

Important Note: Please note that, under the policy terms and condition, the policy may be void if any information provided in this claim form are made knowingly by you that it is materially false or misleading.

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Mailing Address: 1 Pickering Street #10-01 Great Eastern Centre Singapore 048659

Tel 6248 2000 Fax 6532 3478 Website: greateasternlife.com

GROUP PERSONAL ACCIDENT MEDICAL EXPENSES CLAIM
INSURED MEMBER'S STATEMENT

Great Eastern
A Member of the OCBC Group

Important Note : (a) The Great Eastern Life Assurance Company Limited is hereby referred to as "the Company".
(b) The Company does not admit liability by the mere issue of this or any other form.
(c) This form must be completed by the Policyholder and signed by an authorised representative.

1 STATEMENT BY POLICYHOLDER (SCHOOL)

Name of Policyholder : SINGAPORE SPORTS SCHOOL LTD

Policy No : G0003567

Policy Commencement date : Day 01 Month 01 Year 2015

Claim settlement will be via bank GIRO. Please provide payment details below.

Name of Payee : _____ NRIC/FIN no

Nationality of Payee: _____ Date of birth (Day / Month / Year)

Relationship of Payee to Student ☐ Parents / Legal Guardian ☐ School Teacher Sex ☐ Male ☐ Female

Name of Bank	Branch of Bank	Bank Account Number	Account Holder's Name

Name of Student :

NRIC/FIN/ BC No : Date of Birth (Day / Month / Year) Sex ☐ Male ☐ Female

Sum Insured : Enrolment Date (Day / Month / Year)

2 DECLARATION BY POLICYHOLDER (SCHOOL)

We, the Policyholder, declare that the information given in this statement is true and complete and have not withheld any material fact to the best of our knowledge and belief. We agree that the furnishing of this form, or any other supplemental forms, by the Company shall not constitute nor be considered an admission by it that there was any insurance in force on the Insured Member in question nor a waiver of any of its rights or defences.

By providing the information set out above, I/we agree and consent to Great Eastern, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") collecting, using, disclosing and sharing amongst themselves my/our personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate my/our proposal/claims and to provide the relevant products or services which I am /we are applying or have applied for (including claims, without limitation, any policy renewals and policy upgrades, substitutions or replacements).
These purposes are set out in Great Eastern's Privacy Statement, which is accessible at http://www.greateasternlife.com/sg/en/privacy-and-security-policy.html and which I/we confirm I/we have read and understood.

Authorised Signatory & Date :	Name of Authorised Signatory :	School's Stamp :

3 STATEMENT BY INSURED MEMBER (STUDENT)

Name of Insured Member :

NRIC/FIN/ BC No : Date of Birth (Day / Month / Year) Sex ☐ Male ☐ Female

4 DETAILS OF ACCIDENT

(a) Date & Time of Accident: Day | Month | Year | Hour | Minutes : | ☐ AM ☐ PM

(b) Place of Accident: _____

(c) Describe in detail how the Accident happened.

(d) Describe the Insured Member's injuries.

(e) Were there any eye witnesses to the accident? Yes ☐ No ☐

If "YES", give name(s) and address(es) of witness(es).

Name of witness	Address

(f) Was the accident reported to the police? Yes ☐ No ☐

If "YES", please provide the name of the police division & police officer-in-charge's name & contact number.

(Enclose a copy of the police report.)

(g) Name and Address of Doctor who first attended to the Insured Member after the accident.

(h) Date when the Doctor first attended to the Insured Member. Day | Month | Year

(i) Name and Address of Doctor now in attendance, if not the same as above.

5 RECORD OF MEDICAL CONSULTATIONS

(a) Provide the details of any doctors who have been consulted in connection with the Insured Member's illness:

Name(s) of Doctor	Name(s) of Clinic(s) / Hospital(s) and Address	Date(s) of First Consultation

(b) Provide the name(s) and address(es) of the Insured Member's regular doctor(s).

Name(s) of Doctor	Name(s) of Clinic(s) / Hospital(s) and Address	Tel No.(s)

6 PERIOD OF MEDICAL LEAVE - TO BE SUPPORTED BY MEDICAL LEAVE CERTIFICATE (DD/MM/YY)

Full Medical Leave		Light Duties Medical Leave	
From (Day/Month/Year)	To (Day/Month/Year)	From (Day/Month/Year)	To (Day/Month/Year)
1			
2			
3			
4			
5			

(a) Is the Insured Member still confined to House / Hospital? Yes ☐ No ☐

7 OTHER INSURANCES

Is the Insured Member claiming from any other insurance company or other sources in respect of this illness?

Yes ☐ No ☐

If "YES", provide the following information.

Name of Insurer	Date of Issue	Sum Insured	Type of Plan	Claim Amount	Claim Notified YES	Claim Notified NO
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

8 DECLARATION BY INSURED MEMBER / PARENT / LEGAL GUARDIAN

I declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted. I agree to the Company seeking information in connection with this claim from any source and I authorise the giving of such information. A photocopy of this authorisation is as valid as the original.

By providing the information set out above, I agree and consent to Great Eastern, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") collecting, using, disclosing and sharing amongst themselves my personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate, admit, process and/or settle my claims. These purposes are set out in Great Eastern's Privacy Statement, which is accessible at http://www.greateasternlife.com/sg/en/privacy-and-security-policy.html and which I confirm I have read and understood.

Signature of Parent / Legal Guardian / School Teacher

Name of Parent / Legal Guardian / School Teacher

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GROUP PERSONAL ACCIDENT CLAIM FORM

CLINICAL ABSTRACT APPLICATION

FOR OFFICIAL USE ONLY
Claim No :
PID No.:

Form completed by the (please tick one box)

- ☐ Patient (if aged 21 years and above)
- ☐ Parent or Guardian (if Patient is a minor)
- ☐ Next of Kin (if Patient is deceased) **

** Relationship to Patient (if Next of Kin) : _____

Group Policy No.	
Name of Patient	
NRIC / PP / BC No.	
Period of Hospitalisation	to

I hereby authorise any hospital, physician, or other person who has attended to or examined * me / my child / the above Patient, or is authorised to maintain the Patient's medical records, **to disclose to** (or when requested to do so by) The **Great Eastern Life** Assurance Company Limited **any and** all information with respect to any illness or injury, medical history, consultations, prescriptions or treatment of the Patient. A photostat copy of this authorisation shall be considered as effective and valid as the original.

Patient's Admission / E Unit / Outpatient / Clinic * Number was _____

Signature of ***Patient or Guardian / Parent or Next of Kin**

Name : _____
BLOCK LETTERS

Address : _____

Date : _____

Signature of **Witness**

Name : _____
BLOCK LETTERS

Address : _____

Date : _____

**** Delete as necessary***

GROUP PERSONAL ACCIDENT CLAIM
DOCTOR'S STATEMENT

Great Eastern
A Member of the OCBC Group

Important Note: The Insured Member, named below, is insured with the Great Eastern Life Assurance Co. Ltd against the happening of certain contingent events associated with his/her health. A claim has been submitted and to enable us to access the claim, we will be obliged if you would complete this Doctor's Statement. The fees for the completion of this form shall be paid by the claimant.

Name of Insured Member: :

NRIC / Passport No. :

1. (a) Date of Accident: Day Month Year

(b) Date of first consultation: Day Month Year

If the Insured Member had consulted another doctor before consulting you, please give name and address of that doctor.

2. (a) Please describe nature and severity of the injuries / disabilities.

(b) Are there any *permanent body defects* sustained by the Insured following the accident after the injuries has been stabilised with no improvement or deterioration is expected?

Yes ☐ No ☐

If "YES", please give full details of the extent of loss of use of the Affected Part or Site and the percentage of Permanent Incapacity.

(c) If further recovery is expected please give details below.

(d) Describe in detail how the accident happened.

(e) Were the injuries the result of the accident described above? Yes ☐ No ☐

(f) Was the Insured Member under the influence of alcohol at the time of the accident? Yes ☐ No ☐

If "YES", please state blood alcohol content: _____

(g) Did the injuries result from a self-inflicted act? Yes ☐ No ☐

If "YES", please give full description.

3. (a) What is the Insured Member's occupation and nature of work?

(b) Please state the period of Total Disability

(i) Period of *Total Disability: From

Day		Month		Year			

To

Day		Month		Year			

(ii) Were medical certificates issued for the above stated period? Yes ☐ No ☐

If "NO", please provide reasons.

(iii) How and to what extent does the Insured Member's total disability prevent him / her from performing all duties of his / her occupation as stated above?

(c) Please state the period of Partial Disability:

(i) Period of **Partial Disability: From | Day | Month | Year | To | Day | Month | Year |

(ii) Were medical certificates issued for the above stated period? Yes ☐ No ☐

If "NO", please provide reasons.

(iii) What are some of the duties and to what extent of the Insured Member's occupation that he / she is unable to perform as a result of his / her partial disabilities?

Note: * Total Disability refers to disability which prevents the patient from performing each and every duty of his occupation.
**Partial Disability refers to disability which prevents the patient from performing one or more duties of his occupation.

(d) If the Insured Member is still totally disabled, how long is the total disability expected to last?

(e) If the Insured Member is still partially disabled, how long is the partial disability expected to last?

(f) If Insured Member had been hospitalised or had undergone surgery, please state:

(i) Date admitted: Day | Month | Year

(ii) Date discharged: Day | Month | Year

(iii) Name of Hospital:

(iv) Nature of Surgical Procedure.

(v) Date of Surgical Procedure: Day | Month | Year

(vi) Is further surgery likely to be required? Yes ☐ No ☐

If "YES", please specify tentative date of surgery: Day | Month | Year

4. (a) Was the Insured Member suffering from any illness / infirmity which was likely to protract the period of disability?

Yes ☐ No ☐

If "YES", please give details like date of diagnosis , diagnosis made, name & address of doctor who made the diagnosis and how it protracts the period of disability.

(b) Please also comment the usual recovery time of the injuries if the Insured Member did not have these other illness.

5. Has the Insured Member been admitted to any hospital before, either for the same or different cause?

Yes ☐ No ☐

If "YES", please state:

Period(s) of Hospitalisation	Diagnosis	Hospital	Name(s) of Attending Doctor(s)

6. Please provide us with any other additional information that will enable the Company to assess this claim.

Signature of Doctor/Surgeon

Date :

Day		Month		Year			

Name, Address and Qualification of Doctor/Surgeon
(*To affix Doctor's Stamp*)